Sandston Primary Care

35 E Williamsburg Rd.

Sandston, Va. 23150

Phone (804) 737-7804 Fax (804)737-0457

Welcome to Sandston Primary Care. We look forward to helping you with your primary healthcare needs.

Below are answers to some of the questions we are frequently asked by our patients:

* Our office is open Monday through Friday from 8:00 a.m. until 5:00 p.m. We are closed for lunch between 1:00 p.m. and 2:00 p.m. You may reach us by phone after 8:30 a.m.
* **Copayments are expected at the time of service as required by your insurance company.**
* Self-Pay patients are required to pay for their visit in full at the time of service.
* We ask that you bring you medications to each visit. We require that your insurance card(s) be brought to each visit as well.
* If you need to cancel an appointment, please call us right away. **Without a 24 hours' notice or if you do not show up for your appointment, there will be a $25 fee.** Appointment time is set aside just for you, and if you are not able to use it, we would like to offer that time to another patient who needs to see the physician.
* If you find that you are running later for an appointment, please call to see if we can still accommodate your visit.
* If you need a preoperative history and physical for upcoming surgery, please call us **immediately** for an appointment so we can allow time for any required pre-op testing results.
* Please make us aware if you have a visit to the emergency room, an urgent care center or if you are admitted to a hospital. It is best to call us when you return home as opposed to making us aware at your next visit.
* **For most letters and forms, such as insurance forms, back-to-work forms, disability forms, employment forms, etc., there is a charge of $25 to $50 depending on the complexity.**
* Regarding referrals, Dr. Khan must evaluate your condition prior to you setting up an appointment with a specialist. Once he has approved the referral, the appointment should be set up, and you should call our office at least 48 hours prior to your time to process the referral. Without this notice, you may be required to reschedule your specialist appointment. Retroactive referrals are not issued.
* **Prescription refills are best handled at your office visits. If you are in need of a refill at any other time, please have your drug store or mail order pharmacy fax the request to us at 804-737-0457. They also have the option of electronically submitting your request to our office. It is important that you not wait until you are completely out of a medication before asking for a refill. Please allow 48 hours for your prescription request to be processed.**

Please let us know at any time if you have additional questions or concerns.

***PLEASE RETAIN THIS INFORMATION FOR FUTURE REFERENCE.***

**INFORMED CONSENT**

In consideration of Sandston Primary Care, Inc. providing medical services to the undersigned or dependent, the undersigned gives informed consent to the treating physician to administer such medication and anesthetics and to perform such medical and/or surgical procedures deemed necessary by the treating physician. The undersigned also enters into this agreement to be bound by the following conditions: guarantees payment of this account, payment is due at the time of service unless arrangements have been made in advance to pay by installments. Sandston Primary Care will assist in filing of insurance, it is understood that this in no way relieves the undersigned from personal liability for payment of all charges; the undersigned authorizes Sandston Primary Care to furnish all required information to your insurance carrier(s) including diagnosis and nature of treatment; it is agreed that any payment by insurance carriers are hereby assigned and will be paid directly to Sandston Primary Care; should it become necessary to refer this account to an attorney or outside collection agency, the undersigned agrees that all costs of collection, including attorney's fees of twenty five percent (25%) of the unpaid balance, will be added to the balance due; the undersigned is responsible for all bank fees incurred by Sandston Primary Care for returned checks.

Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FOR MEDICARE PATIENTS ONLY LIFETIME FORM

YOUR SIGNATURE IS MANDATORY BY MEDICARE

 Beneficiary Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Medicare Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I request that payment of authorized Medicare benefits be made on my behalf to Sandston Primary Care for any services rendered. I authorize Sandston Primary Care to release all medical information about me to the Health Care Financing Administration needed to determine these benefits or the benefits payable for related services.

 Beneficiary Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sandston Primary Care**

**Shuja U. Khan, MD.**

**35 E Williamsburg Rd.**

**Sandston, VA. 23150**

**804-737-7804**

**804-737-0457 Fax**

Date:

**REQUEST FOR RELEASE OF MEDICAL RECORDS**

|  |  |
| --- | --- |
| **ATTN:** |  |
|  | (Physician or Practice Name) |
|  | (Address) |
|  | (City (State) (Zip Code) |
|  | (Telephone Number) (Fax Number) |

The patient listed below has requested that we obtain medical records from your office. You can mail them to the address above or fax them to our secure fax line listed above.

\*\*If you are a specialist and our patient sees you on an ongoing basis, could you please add Dr. Khan's name, phone and fax numbers to your profile of our new patient and continue to fax chart notes and test results after he/she has visits to your practice.

|  |
| --- |
|   |
|  (Patient's Name) PRINT |
|  (Address) |
| (City) (State) (Zip Code) |
| (Patient's Date of Birth) (Patient's Social Security Number) |
| (Patient's Signature) (Date) |

 \*\*\**Note to patient*: Please let us know if more than one physician is involved in your healthcare. We will be glad to supply you with more copies of the form or you are free to make your own copies.

**PATIENT REGISTRATION** Date:

|  |
| --- |
| Name (First, MI, Last): |
| Date of Birth: SS#: |
| Gender: M\_\_ F\_\_ Marital Status: Single\_\_ Married\_\_ Divorced\_\_ Widowed\_\_  Legally Separated\_\_ Partner\_\_  |
| Address: City, State, & Zip Code: |
| Home Phone: Cell Phone: |
| Employment: Full time; \_\_\_\_\_ Part Time; \_\_\_\_\_\_ Unemployed; \_\_\_\_\_ Retired; \_\_\_\_\_ Active Military\_\_\_\_\_Student Status: Full Time Student; \_\_\_\_ Part Time Student; \_\_\_\_ Not a Student; \_\_\_\_\_  |
| Employer: Work Phone:  |
| Emergency Contact Name & Relationship: Emergency Contact Phone:Do you have a living will? Yes\_\_\_ No\_\_\_ |

|  |
| --- |
| Preferred Language: English; \_\_\_\_\_\_ Spanish; \_\_\_\_\_\_ Other; \_\_\_\_\_\_ Education level: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Race: Ethnicity:\_\_\_White \_\_\_ Cuban \_\_\_ Black/African American \_\_\_ Mexican, Mexican American or Chicano\_\_\_ American Indian or Alaska Native \_\_\_ Puerto Rican\_\_\_ Asian Indian \_\_\_ Other Hispanic, Latino, or Spanish Origin\_\_\_ Chinese \_\_\_ Not Hispanic or Latino\_\_\_ Filipino\_\_\_ Guamanian or Chamorro\_\_\_ Japanese\_\_\_ Korean\_\_\_ Native Hawaiian\_\_\_ Other Asian\_\_\_ Other Pacific Islander\_\_\_ Samoan\_\_\_ Vietnamese *(****RACE AND ETHNICITY ARE REQUIRED FOR*** \_\_\_ Other ***ELECTRONIC RECORDS BY THE GOVERNMENT)*** |

|  |
| --- |
| Referred By: |

**Responsible Party Information**

Responsible Party \_\_Another Patient \_\_Guarantor \_\_Self

Responsible Party Name (Last) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (First) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MI) \_\_\_\_\_

Guarantor Account Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: MM\_\_\_ /DD\_\_\_ /YYYY\_\_\_\_

Social Security Number \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_ Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex \_\_F-Female \_\_M-Male

Address line 1 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Insurance Information (Please have insurance card ready for viewing)**

Insurance company/ Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_) \_\_\_\_\_\_\_\_\_

Name of insured\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Relationship to Insured\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber ID (Policy Number) \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group ID \_\_\_\_\_\_\_\_\_\_ Copay Amount \_\_\_\_\_\_\_\_\_\_\_

Effective Date\_\_\_\_\_\_\_ Termination Date\_\_\_\_ Date of Birth \_\_/\_\_/\_\_\_\_

**Secondary Insurance Information**

Insurance Company/ Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_) \_\_\_\_\_\_\_\_\_\_

Name of Insured \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Relationship to Insured \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber ID (Policy Number) \_\_\_\_\_\_\_\_\_\_ Group ID \_\_\_\_\_\_\_\_\_\_ Copay Amount \_\_\_\_\_

Effective Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Termination Date\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_/\_\_/\_\_\_\_

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

***Patient (or Responsible Party) Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

**Medical Information**

**Social History**

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How Long: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you exercise? Yes\_\_\_ No\_\_\_ How many times per Day/week/Month? \_\_\_\_\_\_\_

Do you use:

Tobacco: Yes\_\_\_ No\_\_\_ How many a day? \_\_\_\_ Years of use? \_\_\_

Alcohol: Yes\_\_\_ No\_\_\_ How many a day? \_\_\_\_ Years of use? \_\_\_

Caffeine: Yes\_\_\_ No\_\_\_ How many a day? \_\_\_\_ Years of use? \_\_\_

Recreational Drugs: Yes\_\_\_ No\_\_\_

Have you ever lived abroad? Yes\_\_\_ No\_\_\_

**Family History**

|  |  |
| --- | --- |
| Disease | Relative |
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**Medical History** (please check if applicable)

High Blood Pressure \_\_ Stroke \_\_ Anxiety \_\_

Thyroid Disease \_\_ Lung Disease \_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Digestive Disorders \_\_ Diabetes \_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Kidney Disease \_\_ Liver Disease \_\_

Seizure Disorder \_\_ Prostate Disease \_\_

Arthritis \_\_ Depression \_\_

Heart Disease \_\_ Cancer \_\_

Do you currently see any specialists? If so, please name. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any known Drug Allergies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any known Environmental or Food Allergies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgical History** (Please check if applicable)

|  |  |
| --- | --- |
| Procedure | When? |
| Tonsillectomy \_\_ |  |
| Hernia Repair \_\_ |  |
| Appendectomy \_\_ |  |
| Hysterectomy \_\_ |  |
| Heart Surgery \_\_ |  |
| Gall Bladder Removal \_\_ |  |
| Back/ Spine Surgery \_\_ |  |

|  |  |
| --- | --- |
| Joint Replacement \_\_ |  |
| Limb Surgery \_\_ |  |
| Skin Surgery \_\_ |  |
| Others:  |  |

**Current list of medications, including prescription, over the counter, Herbal, Etc.**

|  |  |  |
| --- | --- | --- |
| **Name** | **Dose** | **How do you take this medication?** |
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**Example:** Norvasc 5mg Once Daily

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| --- |
| Local Pharmacy: |
| Mail Order Pharmacy for Long term medications (if applicable): |

|  |
| --- |
| **Financial Policy** |

\_\_\_**Patient with Insurance:** You are responsible for deductibles, Co-Pays, Non-covered services and coinsurance. Co-Payments are due at the time services are rendered. The remaining balance is due within 1 (one) month of notice from the insurance company. If incorrect insurance information was provided and/or could not be verified, you will be responsible for the balance. If you or your insurance carrier makes a payment exceeding your balance, reimbursement will be remitted.

\_\_\_**Patient with insufficient proof of insurance coverage:** A valid copy of the insurance card **IS REQUIRED.** If you do not present your insurance card, you will be asked to reschedule your visit or pay the balance in full at the time of service. If you pay your visit and subsequently provide your insurance card, we will file your visit and any resulting overpayment will be refunded. **Note: in order to file your insurance, you must present the insurance card within your carriers specified filing period.**

\_\_\_**Patient with non-participating insurance:** If we do not participate with your insurance plan, your claim will be filed 1 (one) time as a courtesy only. If the insurance carrier has not paid the claim within 60 days, the balance will be billed to you and is due upon receipt.

\_\_\_**Patient without insurance (Private Pay):** Payment is due at the time of service. If you cannot pay the balance in full, you must make arrangements with the financial counselor to set up a payment plan.

\_\_\_**Patient with Medicare:** Our office will submit your Medicare charges to Palmetto GBA, LLC, and your secondary insurance. You are responsible for deductibles, copays, and any non-covered services.

\_\_\_**Returned Checks:** There will be a returned check fee of $35 assessed for each returned check.

**I HAVE READ AND AGREE TO THE FINANCIAL POLICY STATED ABOVE THAT APPLIES TO ME.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Patient or responsible party signature) (Date)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Person signing on behalf of patient) (Print name) (Reason patient cannot sign)

**PAD Assessment (Peripheral Artery Disease Questionnaire)**

 **\*\*\*(Only applicable if over the age of 50)\*\*\***

First name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_ Today's Date: \_\_\_\_\_\_\_\_\_\_

Peripheral Artery Disease (PAD) is a common circulation problem in which arteries carrying blood to the legs are not functioning well or become narrowed due to a build-up of plaque.

Fill out this questionnaire so your physician can evaluate whether you may be at risk or have symptoms of PAD.

**CIRCLE YES OR NO on the following questions and check all boxes that apply.**

1. Have you ever been diagnosed with Peripheral Vascular Disease or been diagnosed as having poor circulation?

 YES NO

1. Have you ever had surgeries, balloon procedures or stents in your heart, kidneys, belly, legs, or arms? YES NO If yes, please list dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. When you walk, do you experience aching, cramping or pain in your legs, thighs, or buttocks? YES NO
3. If you answered YES to #3, when do you feel the pain:

 \_\_ After walking 1 block \_\_ Climbing a flight of stairs

 \_\_ After walking 100 yards \_\_ Walking at increased speed

1. If you have pain, does the pain subside with rest? YES NO
2. Do your feet or toes bother you most nights while lying in bed, with relief while they are dangled at the edge of the bed? YES NO
3. Do you have any painful ulcers or sores on legs or feet that do not heal? YES NO
4. Are your legs discolored or bluish? YES NO
5. Check all that apply:

\_\_ I am a current smoker \_\_ I have a history of smoking

\_\_ I have diabetes \_\_ I have a family history of diabetes

\_\_ I have high cholesterol \_\_ I have a family history of high cholesterol

\_\_ I have high blood pressure/ Hypertension \_\_ I have a family history of high blood pressure/Hypertension

\_\_ I have coronary artery disease \_\_ I have family history of coronary artery disease

\_\_ I have had a stroke/ Mini-Stroke/ TIA \_\_ I have a family history of stroke/ Mini stroke/ TIA

**APPOINTMENT CANCELLATION POLICY**

Sandston Primary Care is committed to providing all of our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen.

**Please call us at 804-737-7804 by 3 p.m. on the day prior to your scheduled appointment to notify us of any changes or cancellations. To cancel a *Monday* appointment, please call our office by 3 p.m. on *Friday.***

\*If prior notification is not given, you will be charged $25.00 for the missed appointment. Payment in full is necessary prior to any services being rendered. The payment is non-refundable, and non-transferable.

By signing below, I agree that I was informed of this office policy.

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Patient name)

Date \_\_\_/\_\_\_/\_\_\_\_\_